Statement

The Department of Veterans Affairs makes every effort to provide safe, quality care and, VA is committed to being forthright with those who trust us for their health care. Salisbury VA Medical Center (SVAMC) recently discovered that in some cases, insulin pens prescribed for use on one patient were used on more than one patient. Although the insulin pen needles were always changed, SVAMC discovered that some insulin pens were used on more than one patient. Even though the risk is very low, SVAMC took immediate action to ensure the insulin pens were removed from all inpatient units and to offer testing and treatment to affected patients. VA is committed to ensuring Veterans receive high-quality, patient-centered care.

Background Information and Actions Taken by VA:

Immediate corrective actions were initiated by SVAMC Leadership. These included:

- Discontinuing the use of insulin pens for all inpatient care settings.
- Collecting insulin pens from all inpatient units and returning them to the pharmacy.
- Reviewing and amending the facilities policies and procedures to include procuring insulin pens for demonstration purposes during patient education at time of discharge.
- Intense re-education efforts, which included updating the competencies of all licensed staff on policies and procedures for administering insulin.

The Centers for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA) state that by only changing the needle, patients are put at risk for blood-borne pathogens due to possible back flow into the device. This means that there is a very small risk that patients could have been exposed to the Hepatitis B Virus, the Hepatitis C Virus, or the Human Immunodeficiency Virus (HIV) if they received insulin from a pen that was not restricted to their individual use. Other patients would have no risk of exposure based on practices identified at the medical center. Since SVAMC has not determined exactly when the variation in practice occurred or which Veterans may have been potentially affected by this practice, out of abundance of caution, SVAMC leadership has decided to notify all Veterans who were prescribed the insulin pen during an inpatient stay from September 1, 2010, when the medical center began using these pens, to January 10, 2013, when the issue was detected.

Staff worked immediately to develop an action plan to correct the procedure and identify patients who may have potentially been affected by this event. Two hundred and five (205) patients were identified to be notified and offered serology testing for possible exposure, along with counseling and treatment if necessary.

VA and the VA Mid-Atlantic Health Care Network are committed to providing the delivery of care to our Veterans in a safe, effective, efficient, and compassionate health care environment. VA has been recognized by the New England Journal of Medicine for its patient disclosure policy. VA remains committed to promoting a culture of transparency that enables VA to learn from these events and quickly take the corrective actions needed to improve and maintain the health of our Veterans.

On December 12, 2012, as part of the Veterans Health Administration's (VHA) national review following the discovery of inappropriate use of insulin pens at the VAMC in Buffalo, New York, the National Center on Patient Safety (NCPS) asked VAMCs, including SVAMC, to complete a review of nursing personnel to determine whether insulin pens were being used correctly, i.e., one pen, one dose, one patient only. On January 10, 2013, and again on January 18, 2013, the SVAMC senior executive team learned of two instances where nurses used insulin pens prescribed for one patient on more than one patient. As a result, SVAMC took immediate action to ensure the insulin pens were removed from all inpatient units and to offer testing and treatment to affected patients.

As part of the full disclosure process, SVAMC will be completing a thorough review and notification to all Veterans potentially affected. This will include the following actions:

- Identifying Veterans who received insulin from an insulin pen during the period in question and preparing the final list for notification process.
- Conducting clinical review of all cases.
- Providing education packets on appropriate use of insulin pens to all applicable staff members.
- A nurse staffed Communication Call Center has been established to conduct initial Veteran notification and manage clinical care follow-up to include:
    - Initial contact regarding the topic;
    - Answering questions and providing pertinent information to the Veteran;
    - Assisting in arranging the necessary blood tests or medical follow up;
    - Documenting patient encounters; and
    - Sending disclosure letters to all potentially affected patients.
- The toll-free number for Veterans to call with concerns over insulin pens is 1-855-286-2248.